Malta Midwives' Journal

The Stork

Malta Midwives Association

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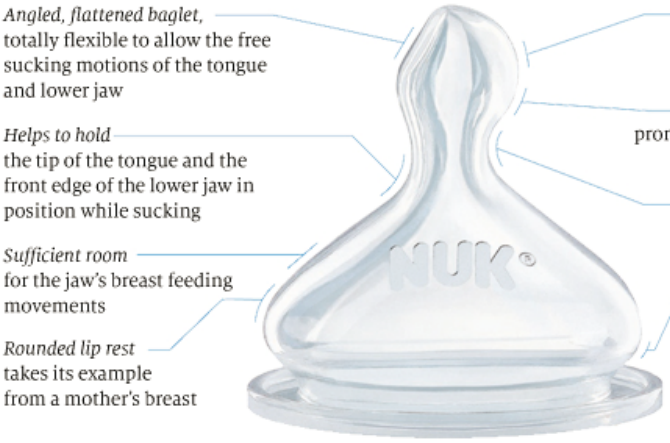

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Front cover:
With courtesy of Ms Charlene Saliba and baby Neil, born on 24/5/16.
Midwife Ms Louise Saliba

Annual Membership €20

Editorial

Dear Members,

The summer season is with us! I hope you are able to slow down from your everyday routines to find time to enjoy summer, and spend time with your family and friends.

The work of the Association is ongoing, and I am very pleased to say that the day by the pool which was followed by a BBQ, held on the 12th July, was very well attended and a success. It was great to see so many of you. This gives the committee a very positive vibe as it fulfills one of the Association's aim - that of promoting and maintaining the unity of its members.

This issue features on the work of the International Confederation of Midwives(ICM). Dr Borg Xuereb gives an overview on the strategies that ICM is globally adopting in order to advance the midwifery profession and to enhance maternal and infant wellbeing. While Ms Pauline Borg writes on her experience and participation in the symposium, ' *Young Midwives in the Lead'* held in Copenhagen last May.

To continue in the quest to understand the Maltese midwifery history, a short biography of Ms Raffaela Farrugia, who was one of the pioneers to work within the community, is included.

An article regarding informed consent in maternity care by Ms Rebecca Mizzi provides an insight on the importance of communication and the right of unbiased information before women/parents sign the letters of consent. Furthermore, Ms Gilliane Fenech continues her article from previous issue on '*Dillemas in the Second stage of Labour'*. A summary of a systematic review written by Analise Gingell presents the findings of induction of labour by membrane sweep while Ms Annalisa Agius debates the issue of eating and drinking during labour. Finally, Ms Katrina Dimech explores sensory skills and how these ameliorate the care of the neonates in the NPICU.

Two local doctoral research summaries and two MSc degree abstracts have also been included for your interest. Here, I would like to take the opportunity to congratulate the graduates for their hard work and determination. Well done!

For your diary: The committee is holding a two day conference on the 17th and 18th November, *'Optimising Maternal and Child Health Care'* with the participation of local and international speakers. Please take note of the dates. Further information and the programme of the conference will be provided shortly.

I would like to take the opportunity to thank all the midwives who contributed to this publication. It is very encouraging and promising to find midwives who are eager to write. Who knows, maybe one day they might be writing midwifery books!!! I look forward to that day.

Pauline Fenech
Editor

Forthcoming events

Malta Midwives Association Conference: 17th – 18th November 2016
Optimising Maternal and Child Health Care

RCM Annual Conference 19th – 20th October 2016
Harrogate International Centre, UK http://www.rcmconference.org.uk/

Midwifery Today Conference: Birth is a Human Right Issue, Strasbourg, France.
19th – 24th October

Annual Baby Friendly Initiative Conference: 3rd – 4th November,
at the Birmingham International Convention Centre
http://www.unicef.org.uk/BabyFriendly/Health-Professionals/Conferences/This-years-conference/

Royal College of Midwives (RCM) - 5th European Midwives Association Education Conference:
2-3 December 2016 at QEII Centre London.

British Association of Perinatal Medicine: Annual General
and Scientific Meeting 2016
15-16 September 2016, Watershed, Bristol. http://www.bapm.org/meetings/

Neonatal Update 2016: the Science of Newborn Care 2016
28 November – 2 December 2016, London, UK
http://www.medical.theconferencewebsite.com/conference-info/neonatal-update-2016-the-science-of-newborn-care-2016

EiP Excellence in Paediatrics
8th Edition, 8-10 December 2016 London
conference,ineip.org

Message from the President

Investing in midwives is investing in the health of the mother, the baby and the family: investing in a healthier generation. Midwives are the key in providing cost effective and efficient care that values women, babies and their families.

However, despite putting all our efforts to give our very best care, the system is still restraining us from reaching our full potential. We have the heart to feel and the eye to see. However, our limited involvement with women in the pre-conception period, antenatally and the constraint to work in the dominating world of medicalisation are limiting our potentiality. We are underutilising the precious art and science of midwifery; the essence of our midwifery care and undermining the back to basics.

Colleagues, we need to recognise the need on how we can influence the environment in which we live in, to know the evidence and use it. The answer is in our hands. What impact does midwifery care leave on families and on the nation? We must learn to communicate with the language that policy makers understand.

The presence of a midwife not only decreases mortality and morbidity rates but promotes holistic wellbeing. Midwives lets continue to work hard to widen our practice and knowledge in order to facilitate the delivery of midwifery care according to our scope of our practice. Expectant parents have the right to access a midwife, to be empowered, to be provided with freedom of choice and with person centred safe care. Midwifery is also the means to reduce the high government expenditure without compromising the quality care for the individual needs of the families. As midwives we must strive for the wellbeing of all the family. Midwives deliver excellence!

Mary Buttigieg Said
President

Treasurer's Message

Over the past months, the MMA has organised a number of social activities, with the help of its committee members. However, such initiatives have no value unless the members participate in these activities. Your presence and participation can serve as encouragement.

In this regard we wish to heartfully thank all those of you who participate whenever the MMA organises one of its activities. It is thanks to a number of you who regularly attend and provide input that the Committee continues to strive to come up with these plans.

Unfortunately, however there are a number of individuals who rarely, if at all, join in. At times there are valid reasons, including personal and family reasons. It is understandable that our work schedule does not allow for much spare time, particularly if one has a family to look after.

However, the committee still believes that particiaption can be improved. I therefore encourage more midwives to join their colleagues at these events. By doing so, team building is fostered as it is easier to engage with your fellow-workers if you also mingle with them in a relaxed, not work-related environment.

For those of you who are interested and wish to take note, the following are the upcoming (and established) events:

Conference in November
Midwives day in May
Annual general meeting in February
Half day seminars

We wish to also put on record our thanks to those midwives who are ''sponsoring'' the Association by giving us their time. When colleagues offer to dedicate some of their free time for delivering classes and/or providing other useful input, that affords the Association to minimise the costs. Hence, the association will be in a position to offer full or partial sponsorship of activities. We are not always aware of this link.

I end this contribution by appealing to everybody's good sense. The Association believes in and, is a proven fact, that by fostering personal relationships during social activities we also serve to consolidate team-building in the wards.

I therefore end with a final plea – do take note of the dates of the upcoming activities and, as of now, book them in your dairies. And please, do answer the emails as it is not easy to plan ahead if one does not have a clear indication of the numbers of participants invovled in a particular activity.

Doris Grima
Treasurer

ICM's Strategies to Support Maternal and Newborn Health and to Advance the Profession of Midwifery

In 2013, while addressing the 2nd global Midwifery Symposium in Kuala Lumpur, Malaysia, Ban Ki-moon Secretary General of the United Nations said that 'investing in the health of women and children is critical for development: Our challenge now is to maintain and accelerate it as we step into this new era for the health of women and children'. The paper will give an overview of the present global situation with regards to maternal and newborn health, and present a critical analysis of ICM's strategies to advance the profession of midwifery and support the sexual, reproductive, maternal and neonatal health in all countries of the world.

Every year, there are an estimated 139 million births globally. An estimated 289,000 women will die during pregnancy, childbirth and the postpartum period. Additionally nearly 2.6 million newborns are still-born each year and another 3,000,000 infants will die during the first month of life (ICM, WHO, UNPFPA, State of the world's Midwifery report for 2014).

Although substantial progress has been made in maternal and child health since the launch of the Millennium development goals, in 1990, we are all cognizant that we have not reached these goals, despite the fact that maternal deaths are largely preventable (MDG's report 2014). Nonetheless one has also to acknowledge that globally maternity mortality rate has dropped by 45% between 1990-2013 (MDG5), indicating that these goals are achievable in the future. No woman should die giving life. It is unacceptable that so many lives are being lost when they should have been saved in the 21st century, especially considering that we are living in a technologically advanced era. The year 2015 was the year of Global action terminating in the Launching of the Sustainable Development Goals, 25-27th September 2015.

Maternal mortality is considered the highest health inequity in the world. Research has shown that midwifery services are highly cost effective and vital solutions to the challenges of providing high quality maternal and neonatal care for all women, infants in all countries. (Ten Hoope-Bender P., et al (2014), SoWMy, 2014). However, an estimated 350,000 more midwives are needed on a global level to address this inequity.

Therefore it seems essential for maternity care to be part of a broad human resource health-care strategy that is tailored to meet the country's needs and context, which addresses quality equity and access to care. Governments also play a lead role in terms of provision of adequate funding to educate competent health workers, set up professional regulation to international levels and to provide a positive policy environment that fosters collaboration among professions through their engagement in a health policy dialogue and advocacy efforts at both national and global levels.

The International Confederation of Midwives is the sole global representative of midwives and the midwifery profession and represents more than 400,000 midwives globally. It is governed by an international council made up of delegates from each of its 121 member associations from more than 108 countries across every continent. The council is responsible for setting the strategic directions for each triennium.

ICM envisions a world where every childbearing woman has access to a midwife's care for herself and her newborn. ICM strives to develop the midwifery profession and to ensure that the individuals who use 'the title midwife' are appropriately qualified; that is they posses the competencies which enable them to provide quality midwifery care and that they have been prepared through an education programme which meets global standards. Through research, there is now increasing evidence that care provided by well educated regulated and resourced midwives saves lives (Black et al 2010), and an estimated 3.6 million maternal, fetal and newborn lives can be saved (State of the World's Midwifery Report 2014).

ICM recognises the need to harmonise midwifery education and regulation globally. This helps to profile a midwife as an individual who possesses a well defined set of skills and competencies; educated through a programme which meets global standards and whose work is recognised through the regulatory systems of the country. In recent years ICM strategic directions' focused on **three main pillars** that constitute a strong profession. These are education of the individual members of the profession through an academically sound education programme, regulation of the profession and a strong Association.

Midwives need to possess a specific set of competencies which enable them to meet the demands of the profession and adheres to ICM's the definition of the midwife, also endorsed by FIGO and WHO amongst others. To support the development of the midwifery profession, ICM has developed several documents concerning education, regulation, and association which are all available on the website.

The First Pillar concerns education and ICM has published several documents; these include:

- ICM essential competencies for basic midwifery practice (2010 amended 2013)
- ICM global standards for midwifery education (2010 amended 2013) supported by the model curriculum outlines for professional midwifery education (2012)
- Curriculum concordance map (2013)
- ICM standard equipment list for competency based skills training in midwifery schools (2012)

These documents were produced using academically sound and systematic search led by midwife academics and researchers, to be applied globally. They can serve as guidelines for the development of a quality midwifery workforce; to distinguish the midwife from anybody else working in maternal, newborn and child health, enhance the clear definition of roles when working with other care providers, to facilitate change in policy and practice, and

to ensure quality midwifery services for women, newborns and families.

The documents are useful as advocacy tools, to encourage midwifery schools or governments to review midwifery education programme and curriculum; reference documents to determine job descriptions for midwives; assess whether new midwives coming from other countries can be registered into the host country's register and to ensure midwives in a given country are at the same levels with midwives globally.

The Second Pillar is Regulation of the profession's activities including education and practice. Midwifery is a separate profession based on a very distinct philosophy with its entirety and its unique body of knowledge; bearing in mind, that acknowledging the uniqueness of the midwifery profession does not make other professions like nursing and medicine less important.

This underlines the critical importance of regulation of a profession, for the profession itself, above all for society, since it protects the safety of the woman and newborn receiving midwifery care through its six main functions which are:

- Setting the scope of midwifery practice
- Setting /approving standards for pre-registration midwifery education
- Registering midwives- who can use the title 'midwife'
- Relicensing midwives who remain competent after regulation
- Discipline midwives found to breach standards and
- Setting code of conduct and ethics.

Regulation also

- Provides a benchmark for global standardisation of the regulation of midwives
- Provides the basis for review of existing regulatory frameworks for midwives
- Provides guidance to countries seeking to establish regulatory frameworks for midwives where none currently exist and
- Sets an ideal regulatory direction to underpin and enable autonomous practice of midwives.

Regulation has a strong bearing on the strengths and credibility of the profession. Again these can be accessed from the website.

The last pillar identified by ICM as critical for our profession is nurturing the association of the members into a strong organization which combines the efforts of the profession and presents a visible existence. The Professional/Midwife Association:

- Legally represents the interest of the profession
- Gives identity as it brings together efforts, thoughts ideas of midwives;
- Provides a sense of belonging and pride to its members as it is a visible entity symbolizing the physical existence of the profession and be a focal point for the profession.
- The association is the hub for creativity, leadership and advocacy for policy change **giving power** or nurturing the power within its members to enhance credibility of that profession through collaboration.

Through its members, the Association can:

- Create a powerhouse of professional expertise
- Take the lead in professional matters for the benefit of the community
- Be the advocate of its members, women, infants and families
- Be the gatekeeper to quality care provision
- Work with government, policy makers on development of maternal, neonatal and child health

Consequently the strength of the profession is largely dependent on the strength and capacity of the Association. To support and develop Associations, ICM has developed and used the Member Association Capacity Assessment Tool (MACAT, 2011). This tool has 7 main sections each representing one aspect of the association to assess the actual situation. The results would guide the Association to strategically plan its progress, and future directions. The Association can plan to assess one section at a time or prioritize according to where the need is greatest. Each Association can complete the MACAT every 3 to 5 years to monitor its own progress.

The main objectives for developing these documents are:

- To provide governments with reference documents and tools to use when they are developing the midwifery workforce in their countries
- To provide midwifery education institutions with evidence based resources on which to base midwifery programmes
- To harmonize midwifery education and practice globally in a manner which recognizes different needs in different contexts without compromising quality
- To provide the foundation on which to build midwifery into an autonomous profession.

They can be used by Member Associations, to strengthen the association itself and ultimately the profession in the individual country, region.

ICM's strategic directions for 2014-17, aim to move us to new levels of engagements and effectiveness in collaboration with and in support of our Member Associations. ICM are focusing on five main directions:

- Strengthen midwifery education, continuing education programmes and the role of the midwife as an educator
- Enhance midwives' professional autonomy and ensure midwifery regulation, education and practice is designed and governed by midwives
- Promote midwifery research that enhances and documents evidence-based midwifery practice
- Advocate for midwifery and extend the influence of midwives in policy development that drives service direction
- Pursue strategic collaborations with relevant organizations and networks that share a common interest.

ICM has also been working closely with the United Nations Populations Fund, UNFPA on several programs. In December 2013 the joint "Investing in Midwives Program" ended after five years. ICM and United Nations populations fund UNFPA organized the second Global Midwifery Symposium in Kuala Lumpur, in May 2013, committed to continue their engagement for midwifery and issued a declaration of commitment. In addition, ICM and United Nations populations fund UNFPA have co-chaired the development of the second State of the World's Midwifery Report.

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In the past decade midwives have gained increased visibility and recognition as key providers of sexual reproduction, maternal and neonatal health care. According to the State of the World's Midwifery report: A Woman's Right to Health (SoWMy, 2014), I quote "Midwives when educated and regulated to international standards have the competencies to deliver 87% of this service need." (page iv).

Midwifery is a distinct profession based on a well-defined body of knowledge. We need to reflect on what we have to offer women and their families which differ from other health care professionals. We also need to appreciate this uniqueness as being distinct from nursing or medicine and we need to provide a supportive working and living environment to enable the retention of midwives as they bring the skilled accompaniment to the sexual, reproductive, maternal and infant health care.

Nonetheless collaboration with other health care professionals such as nurses, obstetricians and gynecologists is imperative if we really want to provide seamless and compassionate care to women, children and families.

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International Day of the Midwife 2016

Press Release

May 5th is the International day of the midwife. Every year, the International Confederation of Midwives (ICM) comes up with a theme to help celebrate this profession and recall its importance. The international day of the midwife is an occasion for every individual midwife to think about the many others in the profession, to make new contacts within and outside midwifery, and to widen the knowledge of what midwives' contribute to society.

The theme of the International Day of the Midwife for 2016 is *'Women and newborns: The heart of midwifery'*

One of the set keys for this theme is '*Invest in improving the education and increasing the number of midwives'.* Last year marked the centenary since the local Midwifery Practice Programme was officially inaugurated. It is therefore fitting that the Malta Midwives Association highlights the achievements realised through midwifery education.

It was Dr.Creni in the late 18th century that strove to introduce midwifery education in Malta, and in 1802 Dr. F. Buttigieg was the first Obstetrics teacher to hold midwifery lectures in the Maltese Language. However, midwifery education was initially somewhat inconsistent. However, it is documented that in 1869 Dr. Pisani reorganised the midwifery programme. He designed a 16-month course whereby students were taught both the theoretical and the practical aspect of midwifery. Dr. Pisani was also the author of the first Midwifery textbook written in Maltese. This was published in 1883. Further midwifery books were published by Professor G. B. Schembri. The latter, also formulated the Regulations for midwifery practice which were subsequently legislated by a Government Notice in 1899. Midwives were consequently listed as a profession in the Health Act of 1901 Midwifery activities and responsibilities were regulated by the First Sanitary Ordinance enacted in the same year.

In 1915, six midwives commenced a three year Midwifery education programme leading to a Diploma. It is amazing to note how Midwifery education in Malta evolved since then given that the programme was not held on a consistent basis. In fact for a time the programme was discontinued until 1970 when the school of midwifery was reopened by Ms Elizabeth Thompson. In subsequent years, midwifery education got a much needed boost through the unstinting efforts of Ms. Mary Vella Bondin.

It was on the personal initiative of Professor Rizzo Naudi, that Midwifery Education once again fell under the auspices of the University of Malta. The Midwifery School was amalgamated with the Nursing School into one Division. This Division continued to develop courses on an academic level within the Institute of Health Care, University of Malta. This was now 1988.

In 2008, Dr. Rita Borg Xuereb was the first Maltese midwife to successfully defend her PhD studies. The subsequent year, on 4th June 2009 (with the help of her fellow colleagues), Dr. Rita Borg Xuereb took Midwifery Education to the next level. Midwifery studies now became a Division separate and distinct from Nursing. And in 2010, Midwifery Education was constituted as a fully fledged Department within the Faculty of Health Science.

Maltese midwives have come a long way. Many of them are investing in their studies and continuing their professional education to a Masters and even a PhD level. Midwives are today providing their services at health centres, government hospitals, private clinics or hospitals, in the community and are also conducting antenatal preparation classes for parents expecting a baby. Midwifery is also finding its place in managerial and specialised posts.

The ultimate goal of the International Community of Midwives is to lower the maternal mortality and morbidity rate as well as the neonatal and infant mortality rate. Unfortunately mortality and morbidity remain high in certain societies. That is why governments must continue to increase investment in Midwifery Education. This is the only way to ensure that there are enough qualified midwives to care for pregnant women and newborns. Currently, only 22% of countries have enough midwives to provide the needed care. According to the State of the World's Report (2014), 289,000 women worldwide still die from preventable pregnancy and childbirth causes.

Fortunately in Malta the situation is quite sound. However we must not bury our heads in the sand and ignore what is happening overseas. It is with this in mind that the Malta Midwives Association together with the International Configuration of Midwives applaud midwives around the world for their vocational work. Midwives, the world over stand united in their resolve to encourage governments to boost investment in midwifery care.

Mothers and newborns deserve no less: The world need midwives now and in the future.

Ruth Marie Xuereb
Public Relations

Raffaela Farrugia
60 Year Career in Nursing/Midwifery

As a 17 year old, I joined one of the first groups to start nurse training as a State Registered Nurse, way back in 1954. The Nursing School, was very well run by Sister Aldegonda Farrugia and Sister Federica (both deceased). In those days we used to sleep on the premises (opposite St Luke's Hospital, G'Mangia), for the whole 3 years of our training. As Matron in our sleeping quarters we had Mrs, Manara.

In 1957, I qualified as a SRN and applied to go to the United Kindgom to start my midwifery training. As I was only 20 at the time, I could not start my midwifery training.

In 1958, just 21 years old, I left for England to start my midwifery training at Hammersmith Hospital, in Shepherds Bush since there was no midwifery training in Malta at the time.

After finishing my 1st part of my Midwifery studies at Hammersmith, I proceeded to Guilford and Surbiton to do my part II training. In those days district nursing and midwifery by students, had to be done by bicycle. I still have many pleasant memories of those days.

I came back to Malta in September 1959 and started Community Nursing and Midwifery with the Malta Memorial District Nursing Association (MMDNA). At that time MMDNA was under a board of management and council and run by an English matron.

In 1959, there were about 8 English and 6 Maltese nurses/midwives working on the district. These nurses/midwives were called Queen's Nurses, as MMDNA was affiliated to the Queen's Institute of District Nursing UK.

In the sixties, midwives on the district had to do both general nursing and midwifery. Malta was divided into areas and each midwife was allocated an area, although we also used to do relief on other areas when the midwife on that area happened to be off duty. Until my marriage in 1960, I had to sleep in the Nursing Home as I used to be on call 24 hours of the day, except on my off day. Midwives had to possess a driving licence. Although I had a driving licence I did not like to drive. For this reason I was given an area where I could attend on foot or by bus - Sliema, St Julians, Gzira. When I was called to attend a delivery during the night, I would phone my relatives who used to pick me up from the Nurses Home and drive me to the labouring woman.

We had different bags to carry with us.

- An A/N visiting Bag
- Midwifery Delivery Bag
- Gas and Air Analgesia Apparatus
- Nursing Bag

All these bags were stocked in a cupboard at the Nursing Home in Sacred Heart Avenue, St Julians. Practices were standardised and had to be followed. Bags had to be prepared and cleaned and it was stipulated how often the bags had to be cleaned.For the General Nursing practice, I had to boil the syringes and the needles since I did not have any disposables for my perusal. I also had to sterilize cotton wool and dressings in a hot oven as sterile disposabe packs were unheard of at that time.

Home deliveries were popular in the 60's. Midwives used to book mothers for home deliveries as early as the 12th week of pregnancy, visit the mothers every four weeks up till the 32nd week , every fortnight up till the 36th week and then weekly till delivery. On booking, the mothers were asked to have a letter signed by their family doctor stating that if the need arose during the delivery, he/she will be asked to assist the home birth.

During the antenatal visits, which were done at the woman's home, the midwife does assessments to see whether the woman classifies for a home delivery. Instructions on what to prepare for the delivery were given to the mother so she will have everything ready for the birth. Home deliveries were mostly done by midwives alone. The GP or obstetrician was only called if necessary.

During the delivery and the postnatal care I had to dress up in a gown, cap and mask and only one person was allowed to stay with the mother during delivery. The postnatal visits used to take as much as one hour during the first few days. I used to visit the mother twice a day during the first 3 days after delivery and once daily for 14 days during the puerperium. I have fond memories of these homebirths and still meet with one of these mothers occassionally. These babies that I delivered at home are in their 50's today.

Breastfeeding was the order of the day and very few mothers opted for formula feeding. When the baby did not latch at birth, I used to express colostrum at regular intervals and feed it to the baby. Many a time this minor intervention used to work and the baby latches. On rare occasions, some babies still refused to latch. The line of management at that time was to help the mother to suppress her milk and show her how to bottle feed with formula milk.

In the early 1970's, things started to change and home deliveries started to decrease. Hospital deliveries were becoming more popular for various reasons and most midwives in the community started practising general nursing only.

In January 1971, I was appointed Principle District Nursing Officer (PDNO) of MMDNA. Although I was pleased with this recognition, this position brought an end to my hands-on midwifery experience in the community. I held this post up to December 2000 afterwhich I was asked to stay on as a Nursing Consultant till December 2013.

Nowadays I am officially retired. However, I enjoy doing voluntary work and have joined a humanitarian organisation and offer my services on a volontary basis.

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Midwives in the Lead

Midwifery is at a pivotal and exciting time. Current research and evidence (**Lancet Series on Midwifery 2014**) is progressively showing the value and **necessity** of midwifery care in order to promote maternal and newborn health. Midwives are thus increasingly needed at the forefront, where they can participate in guideline development, policy making and health systems development. In order to drive this growth in the profession and in local maternity health systems, midwives need to take the necessary steps forward in education, leadership and implementation of evidence-based practice. Therefore, there is an urgent need for midwifery leaders **at all levels** including practice, academia and administration.

On a global level such midwifery leaders can be seen in action; raising awareness and driving change for better sexual, reproductive, maternal and newborn health, from a multitude of aspects. Many other midwifery leaders are not so prominently seen, but are nonetheless working at the grassroots, thus forming a critical part of this movement.

Young Midwives in the Lead

Conferences and symposia are golden opportunities for learning and professional development. However, they also provide a hub for activists, researchers and practitioners to meet, network and build communities of like-minded people. With this premise in mind, in May 2016 a symposium was organised entitled 'Young Midwives in the Lead', in Copenhagen, Denmark. This was organised by the UNFPA, International Confederation of Midwives [ICM], World Health Organization [WHO], Jhpiego, H4+, Johnson and Johnson, Laerdal Global Health, Amref Health Africa and other partners. The primary objective was to provide a space for young midwives from all over the world to meet and learn together, and from each other. The focus was naturally on midwifery, maternal and newborn health, women and girls' sexual and reproductive health and child health, among others. This was done with a special interest in the recent Sustainable Development Goals. The symposium was followed by the 2016 Women Deliver, the 4th edition of this Global Conference which was attended by more than 5,500 people.

Thirty three midwives from 30 countries across the world were selected to participate in this symposium. This included Argentina, Afghanistan, Australia, Bangladesh, Benin, Bhutan, Bulgaria, Burkina Faso, Canada, Ethiopia, Hungary, Iran, Indonesia, Kenya, Kosovo, Lebanon, Liberia, Malta, Malwai, Mexico, Morocco, Nigeria, Pakistan, Paraguay, Peru, Rwanda, Uganda, Uruguay and Zimbabwe. As a midwife from Malta, it was a privilege to participate in this prominent event and form part of such a dynamic team of young midwives. The symposium provided the backdrop for young midwives to work with outstanding midwifery leaders, including Frances Day Stirk, President ICM, Nester Moyo, Senior Technical Advisor ICM, Fran Mc Conville, Technical Officer for Midwifery WHO, Mary Renfrew, Professor of Mother and Infant Health & Associate Dean Research,

Peter Johnson, Director Global Learning Nursing & Midwifery at Jhpiego, Geeta Lal, Senior Technical Advisor Midwifery and HRH, UNFPA, Caroline Homer, Director of the Centre for Midwifery, Child and Family Health in the Faculty of Health at UTS, Billie Hunter, RCM Professor of Midwifery, members of the Danish Midwives Association, members of the International Confederation of Midwives [ICM] and many more. These leaders taught, guided and provided valuable insight for the discussion and work undertaken at the symposium.

This multicultural gathering of midwives was amazing in itself and created a powerful energy of people motivated and enthusiastic about a cause. This cause was complex and multifaceted since midwives face many issues, such as the health system they work in, the resources at hand, the characteristics of their community, educational systems, the skills set of the professionals they work with etc. Midwives working in developing countries raised issues of lack of midwives, lack of transport for women seeking care, lack of resources to provide care and at times even a lack of personal safety for the midwives themselves.

Midwives working in developed countries did not face such problems and thus reflected with appreciation on better working conditions and safer maternity care. Nonetheless, the situation in developed countries is far from the epitome of care. Midwifery leaders emphasised that, when seeking care, women could be harmed if *too little* is/can be done or if *too much* is done. The latter was the case for several countries where unnecessary/ outdated interventions, such as restricting mobility during labour, routine episiotomy and routine amniotomy, were reported to be common practice. Midwives reported with regret high rates of medicalisation, Caesarean sections [CS] and maternal and neonatal morbidity. It was noted that this could in turn increase maternal mortality rates, as is the case in the United States [US], where despite advanced resources in health care maternal mortality rates are rising. At *Women Deliver*, Dr. Neel Shah from Ariadne Labs presented ongoing research investigating the reasons for increasing CS rates in the US. CS rates in the US vary from 7-70% for different hospitals. The hypothesis under study is that individual, institutional, and system-wide characteristics of a labour ward unit make that facility conducive to higher CS rates.

An urgent issue raised in the symposium was the fact that several midwives reported being **unauthorised/ unable to practice within their recognised scope of practice** as per ICM competencies (ICM 2013) and WHO recommendations (SoWMy 2014). This was present despite adequate training and sufficient resources. It was interesting and at the same time perplexing to hear midwives from developing countries recounting conducting vaginal twin and breech deliveries on their own, whilst midwives in certain high income countries were not permitted to conduct simple antenatal check-ups, vaginal examinations or assist a vaginal birth autonomously.

Many stories were shared and this created novel insight into the reality of midwifery practice across the world. It was empowering to hear the midwives from Canada; Alixandra Bacon, and Australia; Skye Parson, who provide complete perinatal care, continuity of care and at times home births, with very good outcomes. Samara Ferrara from Monterray works as an independent midwife, despite a lack of recognition of the midwifery profession in Mexico. She conducts homebirths and provides care in the community, whilst advocating for midwifery. Meanwhile, Yoana Stancheva from Bulgaria, despite stringent restrictions to midwifery care, practices in an independent pregnancy clinic, providing services for those women who are aware of the value of midwifery. Several of the young midwives are involved in education; Sodere Nurgi from Ethiopia, works as a lecturer at her local University, with a target to increase the number of midwives in her country so as to meet the demand for proper care for childbearing women. Clementine Ilukol from Uganda recounted how she provides midwifery care in a remote village where basic necessities such as water are scarce, snake bites are a potential occurrence and her personal safety has also been threatened. Despite this yet her passion for the work she does is a joy to witness.

The need to raise the standard of maternal and child health and establish quality midwifery care impelled the discussion in the symposium towards **advocacy, activism** and **social mobilisation**. The issue of **empowerment** was noted as a crucial milestone, significant for both midwives and women. As well established by philosopher Francis Bacon (1597) “Knowledge is Power” and this holds true for both practice and advocacy in midwifery. Education and professional development is a must for midwives to be empowered and validate their practice with scientific grounds. This in turn creates the information needed to empower and bring women on board and to convince others, in particular policy makers and relevant stakeholders, of the data supporting midwifery care.

At present the situation for several countries, including Malta, is that advocacy for midwifery and maternity care must be done ib spaces led by men, hence men and their approach to such issues must be considered. Men undoubtedly form an integral part of women’s sexual and reproductive health and the childbearing process. At *Women Deliver,* men advocating for such issues was not a novel concept. Yemurai Nyoni, a 26 year old youth leader, Founder of Dot Youth Organisation, Team Leader of MOVE! Life Improvement and Mentor in the Executive Committee of AfriYAN, was the first to start a paternity clinic in Zimbabwe to encourage men to take a more active role in the childbearing process. In commenting on his feelings on gender equality he stated; *“My strength is not defined by the weakness of others. When she [woman] realizes her full potential, my life, our countries will be better”.*

The million dollar question was how to trigger successful change. During a roundtable session with the Young Midwives, Dr Anthony Costello, Director, WHO Department of Maternal, Newborn, Child and Adolescent Health recommended Dr. B. R. Ambedkar’s inspiring strategic order of action **“Educate, Agitate, Organize”!**

The woman is unconditionally at the centre in this journey of progress and change. Due to issues of gender inequality women have often been silenced into acceptance of the situation as is. In Malta, midwives

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often observe this, whereby women will voice their disquiet regarding the medicalisation of care yet tend to remain quiet in the presence of the medical profession. A clear explanation of this predicament can be understood in readings on the theory of **power** by Foucault (1977, 1976), which helps explain how women enter a medical relation during pregnancy and birth, where they can be disempowered by their vulnerability in childbearing and as patients, and also by their gender (Lorentzen, 2008). Thus women are compelled to follow the authoritative knowledgebase of medical professionals. Discourse is the tool used to assert power and in medicine such 'biomedical discourse' is used to assert health professionals' power. During the symposium, young midwives were advised that in tackling these issues, part of the solution was that midwives need to familiarize themselves with this biomedical discourse and learn to 'talk the talk'. Concurrently, women and midwives also need to create opportunities where they can criticize and with good reason **question the evidence behind the status quo**.

A recurring theme highlighted both through research and practice was the importance of Respectful Maternity Care. In a session on Compassionate and People-Centred Care, Hermine Hayes Klein, Founder and Executive Director of Human Rights in Childbirth, called attention to the fact that the quality of the care given is deterministic to how women give birth. She asserted that respectful care is not a luxury or an amenity for women who are lucky to have a straightforward or positive birth. Respectful care is a Human Right for all childbearing women. It is shocking to realise that disrespect and abuse occurs during an experience as intimate and beautiful as birth. However this has been widely reported, in the form of subtle disrespect, humiliation, physical abuse, non□consented interventions, breach of patient confidentiality, verbal abuse, lack of dignity, discrimination, abandonment and denial of care (White Ribbon Alliance 2011). On reflection virtually all midwives admitted to have witnessed some form of disrespect or abuse at some point in their career. This could be in the form of belittling the woman for not pushing as is considered to be 'effective pushing' or performing an artificial rupture of membranes without informed consent. Other cases involve verbal coercion for an elective caesarean section for macrosomia, only to discover retrospectively a newborn of average weight. Such experiences can inflict lasting damage and emotional trauma. One of the strategies to this predicament was the formation of the Universal Rights of the Childbearing Woman (White Ribbon Alliance 2011).

There is no way forward that does not include the women, their babies and their families. In their essence, professional practice and health systems must be informed by the clients whom they seek to care for. Hence, midwives need to join forces with women and ground their profession in a set of core values, embracing empathy, integrity, courage, truthfulness and originality. Change can be daunting and may at time seem idealistic. However experiences such as the *Young Midwives in the Lead symposium* and *Women Deliver conference* make the path clearer, the tools sharper and the journey supported by many comrades.

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Ethical Issues for Consent in Maternity Care

The moral and legal importance of informed consent has attracted attention over the last decades. However consent is not a new phenomenon. Documents indicating patients' approval to procedures have been found as early as ancient Greece and Rome. Today, all healthcare professionals are both ethically and lawfully obliged to obtain informed consent from patients. At the beginning of 2015, a mother's birth video depicting an episiotomy carried out despite the mother refusing went viral and started an online campaign for improved consent in childbirth. In 2013, a Childbirth Connection survey based in the United States found 6 out of 10 episiotomies were performed without consent. In the United Kingdom the organisation birthrights found 12% of mothers reported not consenting to interventions during childbirth, with figures rising to 24% for women having instrumental deliveries.

"*Valid informed consent* is premised on the disclosure of *appropriate information* to a *competent patient* who is permitted to make a *voluntary choice*." (Appelbaum, 2007). Valid consent must be a voluntary choice. The patient should not be put under disproportionate pressure or bullied, by healthcare professionals or relatives, into consenting to treatment. It is only in an emergency situation when the patient is unable, due to their physical condition to consent, that consent is not required. We must assume adults have the competence to make the decision unless proven otherwise. Competence to consent is defined as the ability to understand and retain the information given and using the relevant information to make and communicate the decision. The patient does not lack capacity if they make an unwise choice. We cannot assume that competent patients will make the wisest choices. Lack of capacity for informed consent would be due to an impaired brain or mind function at the time of consent. However by definition this presumably applies to the adult. In midwifery we often assist adolescent girls. The girls' parents and partner may or may not be involved in decision making, however it is still her birth experience and her child despite by law still being a minor herself. Therefore adolescents present a challenge for consent in maternity care. The International Federation of Gynecology and Obstetrics (2015), recommend that the intellectually mature minor may decide to consent to or refuse treatment, despite parental or guardians' preferences.

Appropriate information for consent should include any significant risks, alternative treatment options, and risks of not having the treatment/intervention at all. Healthcare professionals are not obliged to provide all the information within their knowledge. However they should provide enough information for the general nature and objective of the treatment to be well understood. Furthermore, information must be provided in a language that the patient can understand. With the influx in migration across Europe, this is becoming an ever increasing challenge.

Information to the mother and her partner should always include risks and implications to the unborn child. When a mother together with her healthcare professionals take decisions for care, they inevitably are also making a decision for the unborn child. Mothers are often the most powerful advocates for their unborn child. However, the legal position of the unborn child is a very controversial topic in reproductive law. Thus, leaving healthcare professionals in a difficult position when the pregnant mother takes decisions that may not be in the best interests of the unborn child. According to Kruske et al., (2013), doctors and to a lesser extent midwives, felt they would override the mothers' wishes for the safety of the unborn child. Conversely, in the same study, the healthcare professionals consistently agreed that women should have control over their childbearing experience, and that this did not compromise safety. Hence the dilemma professionals face with decision making in such circumstances.

Just like the right to consent mothers have a right to informed refusal of treatment or intervention. Refusal may be at the time of care or advance directives for care in the future.

Many women are now opting to prepare a birth plan. Despite not having a formal legal status in the United Kingdom and locally, birth plans should still be respected by midwives and obstetricians, until the mother decides to consent to an alternative plan of care. Should a mother's birthplan be clinically contra-indicated, appropriate information should be provided. The individual circumstances and health of each mother should be taken into consideration, together with her birth plan, when taking decisions together with the mother in labour. Birth plans can be utilised as documentation of consent or refusal of consent, should a mother later challenge the care received.

Therefore consent goes beyond asking the mother to sign a paper for the purpose of documentation. Ethically, providing information goes beyond obtaining consent, and is important for aiding an informed decision by the mother. However, decision making in clinical practice is not always straight-forward. Healthcare professionals must guide patients and keep them fully informed, while respecting their personal beliefs. The International Confederation of Midwives (2008), encourages midwives to respect mother's informed choice and empower mothers to participate in decision making.

Case Study: Food for thought

Amber Marlowe Gravida 7 Para 6, had delivered her six children by normal vaginal deliveries, all being big

babies. When she went into labour with her seventh, she brushed off doctors, who told her the 4.9kg girl could be delivered only by Caesarean section. But the medical staff at Wilkes-Barre General hospital wouldn't budge, not even with her track record. "All my others, I've done naturally," Marlowe recalled telling her physicians. " I know I can do it." So Marlowe checked herself out and went looking for a new doctor. While she was on her search, Wilkes-Barre General's lawyers rushed to court to get legal guardianship of her unborn child, giving the hospital the ability to force Marlowe into surgery if she returned. Marlowe ended up at another hospital, where she had a quick, natural birth she described as "a piece of cake". What she didn't know then was that when she went looking for a new doctor, lawyers for Wilkes-Barre General had rushed to court for legal guardianship of her unborn child, giving it the ability to force Marlowe into surgery if she returned. Marlowe only learned about the case when her husband was told by reporters. " I couldn't believe it," she said. " They don't even know me from anything and they're making decisions about my body? It was terrifying."

Can a mothers' right to autonomy conflict with the unborn child's best interests? What rights if any does the unborn child have? Courts, in the United States and United Kingdom, have never forced surgery onto someone for the benefit of another born person (for example in the case of organ transplantation), however courts can enforce caesarean section for the wellbeing of the unborn child.

Is defensive practice in obstetrics impairing informed consent and decision making? Has it become easier to scare women into taking the decisions the practitioner desires rather than informing and communicating with women? Communication remains of paramount importance during antenatal and intrapartum care. Where there is lack of choice in childbirth women may start opting to birth unassisted at home for fear of undesired interventions while at hospital or with an assisted homebirth.

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Nutrition in Labour

Until the mid-1940s women were wildly encouraged to keep well hydrated and eat a light diet during labour to maintain their stamina for the work associated with giving birth. At that time obstetric textbooks such as '*Midwifery by Ten Teachers'*, published in 1931, encouraged this practice. In 2000, the '*Guide to Effective Care in Pregnancy and Childbirth* published' that food and drink should be withheld once labour has commenced'. So what changed?

The practice of withholding food and drink during labour has been accepted in most hospitals around the world and remains a controversial issue until today. Women are not allowed to eat and drink during labour to prevent aspiration should they require general anaesthesia for delivery. This policy dates back to 1946 after Curtris L. Mendelson published a study on gastric acid aspiration (Parsons et al., 2006). Seventy years ago, aspiration was a common complication of general anaesthesia. A review of the literature published after Mendelson's study showed an increase in the maternal mortality rate due to anaesthesia related aspiration during the first twenty years following the study, despite the introduction of withholding oral intake during labour. Most of those deaths were caused by complications related to intubation (Marcel, 2015). With recent advances in techniques such as rapid induction of sedation and tracheal intubation, use of mediations and an increase in spinal analgesia, Mendelson's Syndrome *(also known as peptic pneumonia refers to acute chemical pneumonitis caused by the aspiration of stomach contents in patients under general anaesthesia*), has become extremely rare. Johnson et al. (1989) state that most cases of aspiration "could be prevented by a combination of decreasing the frequency of procedures that require anaesthesia, the use of regional anaesthesia wherever feasible, and meticulous attention to safe anaesthetic technique". Obstetric anaesthesia has changed considerably with improved general anaesthetic techniques and greater use of regional anaesthesia, however, the practice of starving women during labour due to the questionable risks remains.

No presently known practices can ensure that a labouring woman's stomach is empty, or that her gastric juices will have a pH greater than 2.5 (Johnson et al. 1989). Fasting during labour does not guarantee an empty stomach should general anaesthesia become necessary; no time interval since the last meal can ensure a stomach volume of less than 100 ml. Nor can fasting during labour be relied on to lower the acidity of the gastric contents (Roberts and Shirley 1976). Scrutton et al.'s (1999) randomised controlled trial assessing the risks and benefits of eating a light diet in labour found that it increased the residual gastric volume. Broach and Newton (1988) state that it is the administration of narcotics that appears to be the major factor in delaying stomach emptying (Nimmo et al. 1975; Holdsworth 1978). This would suggest that either other forms of analgesia should be considered, or that oral intake of food should cease when narcotics are given (NICE 2007; Grant 1990).

Pregnant women have increased energy requirements, and need an average increase of 340 calories per day during the second trimester and 560 calories per day during the third trimester (Marcel, 2015). Because of this increase in energy expenditure, pregnant women are not able to go without food for as long as non-pregnant women. Pregnant women go into accelerated starvation very easily. Forty percent of women in normal labour in fact test positive for urinary ketones (Marcel, 2015). Elevated levels of ketos accumulate during exercise or starvation (Williamson, 1971). Considering that women in labour have an increased energy expenditure and are being kept starved, the process of ketones formation becomes augmented even further. The presence of ketonuria should not be taken lightly as it is a sign of metabolic imbalance (Johnson, 1989). Speak (2002) claims that ketonuria can lead to prolonged labour and reduces the efficiency of uterine activity. This in turn brings out the need to use Syntocinon. Therefore, we have moved labour from low risk to high risk simply because we are hesitant to move from routine practices of starvation.

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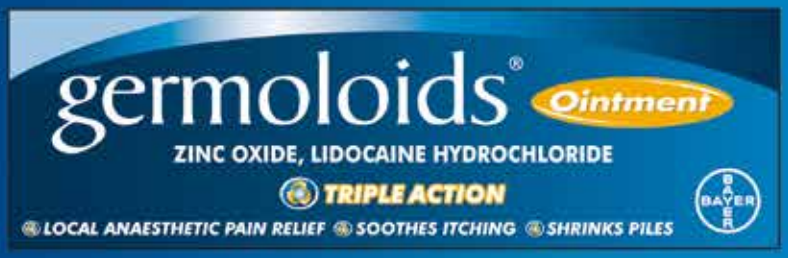

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process of labour (Lamaze International, 2009). Overall, gastric emptying in labour remains the major reason for prohibiting and restricting eating and drinking in labour, even though evidence regarding this remains inconclusive (Sharp, 2007). These restrictions are used routinely with all women even without a specific medical reason but 'just in case' (Lamaze International, 2009). Denying labouring women food can also be seen as authoritarian and intimidating and can increase feelings of fear and apprehension during labour (O'Sullivan et al., 2009). Lewis (1991) argued that the policy of oral intake during labour Appears to be that of professional attitude rather than evidence based.

Whilst some prefer labouring women to be off solid foods since there is no predicting who will need a c-section (Motka, 2010), guidelines state that during labour oral intake of clear fluids (water, fruit juices without pulp, clear tea) may be allowed in low risk women. Besides the stomach never completely empties and prolonged fasting can, in fact cause an increase in gastric volume and an increase in acidity, which can in turn lead to aspiration (Mitka, 2010). During prolonged labour, women who are starved become fatigued and experience increased vomiting and/or show signs of anxiety, which are associated with a higher incidence of fetal distress and lower Apgar score at birth. The increased risk of hypoglycaemia and ketosis induced by starvation reduce the labouring woman's energy and for bearing down and therefore increase the need for assisted instrumental delivery (Marcel, 2015).

Recommendations for Practice.

According to the Confidential Enquiry into Maternal and Child health (CEMAH) (2007) the only reports of adverse effects for the mother and baby were if large volumes of fluids were drunk (7-8 litres) in labour causing water intoxication and babies becoming hyponatremic (low sodium concertation in the blood) (Gyte and Pengelley, 2007).

The Royal Collage of Midwives (RCM) (2005) states that "there is insufficient evidence to support the practice of starving women in labour in order to lessen the risk of gastric aspiration. Women who wish to eat should therefore be offered a light nutritious diet. Fatty foods are known to cause Slow gastric emptying and are therefore usually discouraged (Marcel, 2015).

It is important to recognise that the withholding of food and drink in labour is very much a hospital practice; when women opt for a home birth there is no such restriction (Baker, 1996). Frye (1994) says that eating in labour allows the woman to feel normal and healthy, it keeps her energy up and can minimise complications caused by maternal exhaustion. The psycho-social aspect of fasting should also be considered. The provision of food and drink can be reassuring and comforting. There has been little published work exploring women's views about whether or not they would eat in labour if given the choice. Armstrong and Johnston (2000) found that a significant minority (30%) of women would wish to eat in labour. Newton and Champion's study (1997) found that women appreciated having the option of eating and drinking, even if they chose not to do so. The desire to eat, however, would appear to be most common in early labour (Singata et al. 2010). As Odent (1994) points out, women do not usually wish to eat in active labour and it is inappropriate to be encouraging them to do so, against their natural instincts. This is another area in which we should be responding to what the woman feels she needs, and allowing her to make the decision and take control (DH 1993).

Reliable studies in this field are considered difficult since producing rigorous data to clarify the situation through randomized trial would most probably be considered unethical. Some of the research material available is outdated and there is a lack of investigation on the topic. The information available is quite repetitive and based on Mendelson's syndrome. In light of this evidence and information available, midwives should evaluate own practices based on their own trusts, taking into account the recommendations provided and practice based evidence rather than traditional beliefs.

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Induction of Labour by Membrane Sweeping: a Systematic Review

When a pregnant woman reaches 37 weeks gestational age, it is said that she has reached 'term' pregnancy. Up to 10% of women continue their pregnancy up to 42 weeks (294 days) (Roos, et al.,2010). Such pregnancies are described as 'post-term' or 'postdate'. The latter increases the risk of maternal, fetal and obstetric complications, and thus, induction of labour is generally used worldwide in order to prevent such problems, and improve both the mother and baby's health outcomes. Together with other interventions, membrane sweeping is one method of inducing labour. In research, 'sweeping' and 'stripping' are found used interchangeably, however, the word 'sweeping' was used in this review.

Membrane sweeping is performed during a vaginal examination. With the index finger, the membranes at the lower uterine segment are detached from the cervical os causing a cascade of events, primarily the production of natural prostaglandins, leading to the possibility of cervical ripeness and labour contractions. Prostaglandins - a group of cyclic fatty acid compounds produced by almost every tissue in the body, serve as important messengers or effectors in a wide variety of functions, having varying hormone-like effects, notably the promotion of uterine contractions.

In cases were the membranes are hard to reach, a cervical stretch is done. A cervical massage is performed in situations where the cervix is closed (Arulkumaran, et al., 2011).

Objectives

By means of best accessible evidence, the efficacy and safety of membrane sweeping in pregnant women, for cervical ripeness and induction of labour, during the third trimester of pregnancy was evaluated in this review.

Rationale

Earlier versions of this review were published. Since several years have passed and more research has been published since then, a need for another systematic review was necessary. In addition, to the knowledge of the author, no local reviews on membrane sweeping were ever published. Thus, this review, using a standardised protocol, served as a continuation of the previous systematic review (Boulvain, et al., 2005), and evaluated the method of membrane sweeping with regards to effectiveness and safety, compared with other interventions for initiating labour.

Summary of evidence

The data obtained suggested that membrane sweeping increases the frequency of spontaneous labour. When carried out routinely in the third trimester, membrane sweeping reduced the possibility of post-term pregnancy and the likelihood of induction of labour; with the use of other methods. Such results were consistent with the conclusions of the previous systematic review (Boulvain, et al., 2005). However one must question whether it is appropriate to perform such an intervention bearing in mind the possibility of inducing labour at an early gestational age of 38 weeks in a low-risk pregnancy.

In the latter review (Boulvain, et al., 2005) it was reported that mothers complained of discomfort, bleeding and infrequent contraction during membrane sweeping. Such complaints were not explored in any of the recent eligible trials of this review, except that Mozurkewich, et al. (2011) found no statistical differences in the incidence of vaginal bleeding following membrane sweeping. Thus, more research is needed on this issue. However, when discussing the options for induction of labour, caregivers must still take care to explain this to mothers, together with all of the other possible side effects. In addition, in accordance with the results of Boulvain, et al. (2005), no significant benefits with regards to the major obstetric, maternal or neonatal complications were found when the membranes were swept.

Compared to other methods, membrane sweeping is less predictable and probably in cases of emergencies, sweeping is not appropriate for induction of labour. In fact, although the amount of studies were in minority (Adeniji & Akinola, 2013; Javadekar & Rokade, 2013), Misoprostol was found to be more efficient than membrane sweeping in reducing the time interval from the intervention to delivery, irrelevant of the route of administration. One trial by Mozurkevich, et al. (2011), was in congruence with such results. However, one must be cautious when comparing such conclusions, due to the fact that these trials involved a small population size; a factor which may increase the possibility of deceptive results. The use of different comparison groups (Oral and vaginal), in the individual studies also makes it inappropriate to compare the results.

Thus, further research is necessary to evaluate the efficacy of membrane sweeping compared to prostaglandins. Given that most women in Adeniji & Akinola (2013) and Javadekar & Rokade (2013), agreed on opting for the drug in subsequent post-term pregnancies, begs the question of whether membrane sweeping really is the best option for inducing labour, bearing in mind all the benefits and risks of both methods.

Nonetheless, the inclusion of systematic reviews was a strength in this review. Being the top research design in the research hierarchy (Howlett, et al., 2014) , best evidence

was obtained as much as possible in order to gather the best information available on the efficacy of membrane sweeping.

Limitations

In order to have a complete and comprehensive search, the utmost was done to access full- text articles, however due to limited accessibility; some eligible articles could not be retrieved. This was a limitation of this review, as some potentially good articles could have been missed. Another limitation of this systematic review includes the small sample size of certain studies which could have led to the possibility misleading results.

The inclusion of a language barrier as part of the inclusion criteria may also have affected the results, as the probability of missing relevant articles was increased.

Additionally, the inclusion of articles with a low level of evidence and high levels of biases led to the possibility of producing inaccurate results.

Due to time constraints, the search was done in a short period of time. For reasons of rigor in a systematic review, ideally more than one researcher is involved with the quality assessment and the search, and the latter should be done on a much longer period of time (Holly, et al., 2012).

Implications for future practice

The presented evidence recommends that membrane sweeping stimulates the onset of spontaneous labour. A lower incidence, in using other methods for initiating labour, should be expected within women who had their membranes swept. No evidence was found that membrane sweeping heightens the risk of maternal or neonatal complications or of early rupture of membranes. For this reason, membrane sweeping can be assumed as a 'safe' method providing that the latter is performed on mothers with an uncomplicated pregnancy and with no contraindications to a normal vaginal delivery. Thus, low-risk women in their third trimester could benefit if they have their membranes swept routinely up to delivery.

Implications for research

Subsequent research is needed were membrane sweeping will be studied on women according to their parity and cervical status. This will explore deeper the efficacy of membrane sweeping in specific smaller groups.

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Dilemmas in the Second-Stage of Labour

Part 2

Introduction

In the last edition, I started to explore dilemmas in the second stage of labour. Following a literature review, it appeared reasonable to urge midwives and other health professionals to encourage women to follow their own instincts and their own bodies, and for midwives to support women during pushing instead of directing women. I continued to suggest that midwives should then use their clinical judgment to determine whether direction is required in each specific situation. However, apart from directing women to push, another 'old way' of supporting women in the second stage of labour is to commence pushing immediately at 10cm regardless of whether the woman has an urge to push (Simpson, 2006). In this Stork edition, I would like to explore the dilemmas present in this matter and to explore the concepts of the latent and active phases of the second stage of labour.

Dilemmas

It has been argued that when women are directed to push immediately at 10cm without feeling the urge to push, *'the woman becomes dependent on direction and retains a pattern of following those directions that are often out-of-phase with her own sensations'* (Roberts, 2002). This can result in maternal exhaustion, metabolic acidosis and the need for assisted instrumental deliveries (Crawford, 1983). Crawford (1983) was the first to identify that immediate pushing can potentially be harmful to the mother and the foetus. Since then, a lot of studies have been published showing the risks involved in immediate pushing when women do not have the urge to push (Nordstrom et al, 2001; Hansen et al, 2002; Roberts, 2002). Nonetheless, a dilemma on the most appropriate approach to pushing in the second stage remains as alternative studies have been published which present the risks involved with delayed pushing (Lemos et al, 2015). Due to contradictory data, it remains unclear whether delayed pushing should be promoted to allow a latent period followed by an active phase or whether to initiate an immediate active phase once full dilatation is diagnosed.

Definitions

The NICE guidelines define the latent phase of the second stage of labour from when the cervix is fully dilated before or in the absence of involuntary expulsive efforts (NICE, 2014). The active phase of the second stage of labour is identified when the vertex is visible, when there are expulsive contractions present with full dilatation, or when there is active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions (NICE, 2014).

Arguments in favour of delayed pushing

In the latent phase of the second stage, the presenting part (usually the head) will have time to descend to a station of at least +1 and rotated into an occipito-anterior position (Roberts, 2002). This timeframe will permit '*the head to rotate and descend through the pelvis and reach a level and alignment in the pelvis that will enable expulsion to be accomplished with maternal bearing down'* (Roberts, 2002, pg. 6). Furthermore, these optimal conditions will result in an augmented release of oxytocin which will cause the bearing-down reflex and an involuntary urge to push. Allowing for these optimal conditions to take place through the latent phase of the second stage of labour has been associated with a number of additional benefits.

Hansen et al (2002) carried out a randomised control trial (RCT) to compare perinatal outcomes among women with epidural anaesthesia who were encouraged to push at complete dilatation with those who had a period of rest before pushing began. In this study primagravidas who were randomised to the rest period were given a two-hour latent phase before commencing active pushing, whereas, multigravidas were given a one-hour rest period. It was concluded that delayed pushing had no adverse effects on mother and baby despite the second-stage length of 4.9 hours. A latent phase in the second stage of labour was associated with decreased maternal fatigue, decreased pushing time and fewer decelerations on the FHR pattern (Hansen et al, 2002). Improved APGAR scores were also noted in the delayed pushing group, however, this did not reach statistical significance (Hansen et al, 2002).

A number of other studies (Nordrstom et al, 2001; Roberts, 2002; Simpson & James, 2005) have also shown that delayed pushing promotes foetal wellbeing since women will need to push actively for a shorter period and hence there will be fewer decelerations and less of a negative effect on foetal acid-base status and oxygenation. A few authors (AWOHNN, 2000; Freeman et al, 2003) even suggest a period of rest during active pushing

if the FHR pattern is not reassuring, particularly since active pushing is often the cause of the non-reassuring FHR pattern (Simpson, 2004). By allowing a rest period, the foetus will be able to recover and the mother will regain her strength (Simpson, 2006).

A recent Cochrane review (Lemos et al, 2015) which included 13 studies reported that delayed pushing was not only associated with a 20-minute decrease in active pushing (and a 54-minute increase in the second stage) but was also associated with an increase in spontaneous vaginal birth. Le Ray et al (2011) when comparing the risks of post-partum haemorrhage (PPH) in the presence or absence of delayed pushing found that when active pushing exceeded 40 minutes the risk of severe PPH was a lot higher. This suggests that since a latent phase decreases active pushing, the risk of severe PPH also increases. Additionally, no difference has been reported in the incidence of perineal lacerations or episiotomy, NICU admissions or 5-minute APGAR scores (Lemos et al., 2015).

This evidence suggests that a latent phase is beneficial and enhances positive maternal and neonatal outcomes as it avoids a number of adverse effects such as fatigue, non-reassuring FHR patterns, instrumental deliveries and severe PPH while increasing spontaneous vaginal births. This may suggest that delayed pushing should be promoted even in the presence of a non-reassuring FHR pattern.

Arguments against delayed pushing

However, this is not what the Cochrane review by Lemos et al (2015) concludes in this matter. Lemos et al (2015) report that there is insufficient evidence to justify routine use of any specific timing of pushing since the maternal and neonatal benefits and adverse effects of delayed and immediate pushing are not well established. The review reports that delayed pushing was associated with a greater incidence of low umbilical cord blood pH reported by one study and that effect on the maternal pelvic floor is unknown (Lemos et al., 2015). These implications and uncertainties warrant further research before justifying one specific timing of pushing (Lemos et al., 2015).

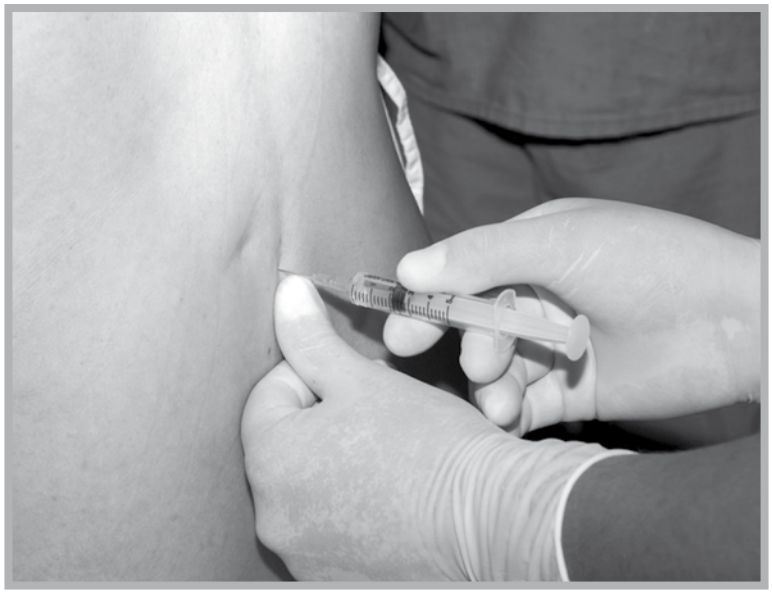
In contrast, Hanson et al (2002) report that there is no significant difference in arterial cord pH values, however, this RCT included a smaller sample (n=252) to the one reported by Lemos et al (2015) (n=1,862). Lai et al (2009) also reported no neonatal morbidity with delayed pushing, however, this also consisted of a small convenient sample (n=72). The smaller sample sizes may explain the different findings. This contradictory data once again justifies the need for further research using larger samples to determine the effects that delayed pushing has on neonatal well-being.

In 2008, Brancato et al, following a meta-analysis of RCTs which explored delayed vs immediate pushing with epidural analgesia also reported that delayed pushing is associated with a greater incidence of low umbilical cord blood pH. However, Brancato et al (2008) conclude that further research is required to explore the effect of delayed pushing on cord blood pHs while controlling for confounders such as length of delay and method of pushing as this has been shown to affect neonatal cord pHs (Roberts, 2002). Additionally, research which is undertaken should also have longer follow-up times and explore the impact delayed pushing has on the pelvic floor, urinary incontinence as well as maternal sexual health (Brancato et al, 2008). Despite the effects of delayed pushing on cord blood pHs reported by one study and the need for further research, the authors conclude that healthy women who have an epidural, without complicated labours and with a singleton pregnancy should be allowed up to a two-hour latent phase until the vertex is visible or until the woman has an irresistible urge to push (Brancator et al, 2008) as it increases the chances of spontaneous vaginal birth and reduces pushing time.

Recommendations

The NICE guidelines (2014) recognise this recommendation as they currently state: '*upon confirmation of full cervical dilatation in a woman with regional analgesia, unless the woman has an urge to push or the baby's head is visible, pushing should be delayed for at least 1 hour and longer if the woman wishes, after which actively encourage her to push during contractions'.* However, the guideline also recommends that the second stage should be no longer than 4 hours, regardless of parity (NICE, 2014).

However, despite these recommendations, the effects of delayed pushing on neonatal cord pHs and the long term effects on pelvic floor muscles remain unclear. Subsequently, it may not be appropriate to delay pushing. On the other hand, it is recognised that instrumental deliveries significantly increase pelvic floor disorders such as urinary stress incontinence, overactive bladder, anal incontinence, prolapse symptoms, prolapse to or beyond the hymen on examination and third or fourth-degree tears (O'Mahoney et al, 2010; Handa et al, 2012). In view of this, it may not be unreasonable to follow the NICE guidelines to delay pushing despite the possibility of lower cord blood pHs, especially since there



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is no evidence of low APGAR scores, NICU admissions or significant neonatal morbidity.

Unfortunately, these guidelines and recommendations only address women who have regional analgesia. Further research is required to determine whether delayed pushing is equally beneficial for women without regional analgesia. A woman without regional analgesia may still not have an urge to push at full dilatation which would suggest a vertex presenting in a sub-optimal position. In such a scenario, the woman may benefit from a latent phase in the second stage to allow the vertex to rotate into an optimal position and to descend further into the pelvic cavity. Theoretically, this can increase the chances of spontaneous vaginal births without maternal or neonatal adverse effects.

Conclusion

After consideration of the literature, it appears that the NICE guidelines are well grounded and that healthy women with a working epidural and with a singleton pregnancy should be offered a latent phase upon confirmation of 10cm, in the absence of a pushing urge. This allows the vertex to descend further and to rotate into an optimal position to increase the urge to push and increase the likelihood of a spontaneous vaginal birth. This will decrease maternal fatigue, the period of active pushing and the risk of severe PPH. Additionally, as the risks of instrumental births are decreased, so will the risks of pelvic floor disorders. Nonetheless, additional research in this field is still required to determine the influence of delayed pushing on the pelvic floor, sexual health and neonatal cord blood pHs.

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Using Assessment Tools to Improve Care of the Neonate, Especially in the NICU Setting

In the NICU setting nurses/midwives have to care for babies that are supposed to have developed in utero. One of the most crucial parts of development in this period is brain development which takes till 2 years to be fully myelenated. The brain develops only when sleeping. Furthermore, sleep is essential to regulate body systems, store energy and develop the senses. According to Als (1998), " all NICU care is brain care".

Preterm infants may not have the ability to handle stress well and it will affect their body systems. This often results in apnoeas and/or bradycardias and even possetting. By using various assessment tools such as the NBAS developed by T. Brazelton and the NIDCAP model. Als (1998) we can learn how to distinguish stressed behaviour in the neonate. According to these models of care, a baby in extension is stressed, while a baby that is capable of self-regulating or comfortable will keep flexed. The baby may also avert his/her gaze.

The NBAS assesses the complexity of behavioural responses to social stimuli as the neonate sleeps and wakes with reflex assessments to monitor neurological integrity and behavioural assessments to determine capacity to respond to stimuli. This can be used as a reflection of the baby's ability to organise his/her autonomic and central nervous system (Brazelton, 1978)

As caregivers, there are a number of neuro-protective care measures that may be taken so as to help the developmental care of the neonate such as:

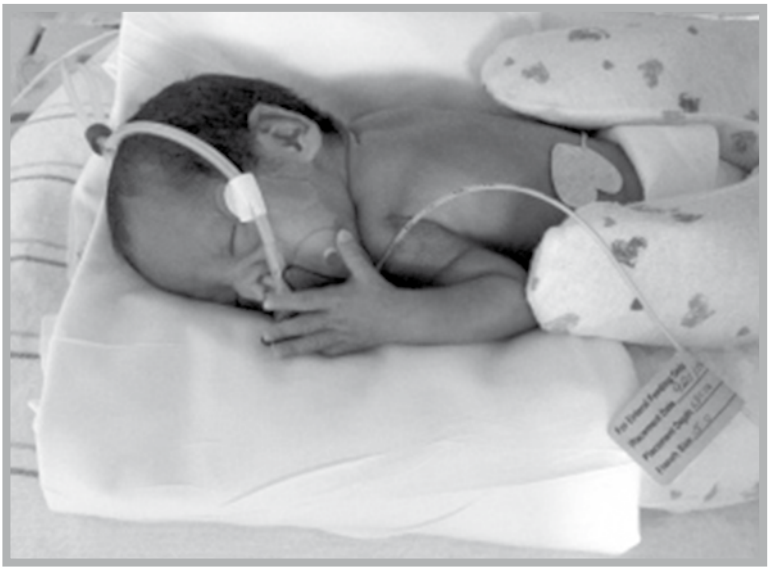
- Safeguarding sleep – providing individualised care based on sleep-wake states
- Infant driven feeding – observing feeding readiness cues, working towards making feeding a positive experience
- Minimising stress & pain – using pain assessment tools, non-pharmacological support and individualised care
- Positioning and handling – using methods such as swaddled weighing and bathing
- Involvement of family – breastfeeding, kangaroo care and rooming in facilities

Simple actions such as approaching the neonate with simple soft touch before proceeding with nursing will allow him/her to acclimatise to your touch while giving you time to observe for behavioural cues. Sudden, unpredictable movements or lifting and turning may elicit startles and set off the autonomic system. Keeping the baby swaddled and supported when turning will minimise these disturbances, as well as keeping the baby close to your body when lifted rather than simply suspended on your hands. If remains unsettled when placed back in the incubator he/she may be nursed prone or lateral in a well supported 'nest' to allow him/her to self-regulate.

"The NIDCAP's goal is to prevent unexpected sensory overload and pain so as to enhance strengths and competences of the neonate" (Als, 2004).

According to the Peter Wolff, babies have different behavioural states and care should be given at the appropriate time frame. This is the basis for developing a system of care which is individualised according to different neonate's needs and their individual sleep wake states. If it were the baby's choice, they would be left without mittens, with the hands together in front of the face in a side lying, retracted position as if they were in utero. This position allows them to self-regulate to outside stressors which by nature they should not even be exposed to.

There are critical periods for sensory development which occur in sequence and cannot be accelerated. Out of phase sensory stimulation may interfere with normal development. Vision is the last sense to develop and requires natural light to develop properly, for this reason pre-terms should not be exposed to bright lights as it would be out of phase, while when approaching term gestation they should be exposed to natural light such as through a window.



Touch is one of the most important senses; which, when interfered with, can affect he neonate for the rest of his/her life. The most sensitive areas are the hands, feet, mouth and nose, and in an NICU setting these are the most interfered with areas because of cannulation, blood sampling and feeding. A preterm will find it difficult to distinguish between soft touches; therefore one must use deep pressure when holding or comforting.

There is also another misconception that pre-term infants do not feel pain, when research now shows that nerve endings are developed by the beginning of the second trimester and foetuses can also feel pain. On the contrary to previous belief, pre-terms will feel pain for longer since

nerve pathways are not yet myelenated. Untreated pain has physical effects and can increase morbidity and mortality in infants. Furthermore, newborns have been known to react with distress behaviours to actions that preceded a previously painful intervention. Using pain assessment with nursing care can help provide better nursing care and pain management and improve neonatal outcomes (Tietjan 2001).

Looking back at all of the above, we can see how as care givers we can play a crucial role in the correct development of NICU babies as there are a number of measures that can be taken so as to help preterm infants handle what would normally be considered stressors. Ideally, we should try implement a system of care that is '*infant-led*' and caters for each neonate's different needs and sleep wake cycles, especially since sleep is essential to help them in regulating their body systems and develop their senses. Lastly, the preterm's nerve pathways are not yet myelenated, which cause pre-terms to feel pain for longer, thus NICU care interferes a lot with the most sensitive areas of their bodies, being, the hands, feet, mouth and nose. Therefore, let us help neonates develop in such a way that will not have negative implications on the rest of their lives, with a Special Care Baby Unit, not just an Intensive Care!

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M.Sc Abstract

Women's Health and Partner's Violence in Pregnancy Survey

The prevalence rate of intimate partner violence (IPV) during pregnancy varies extensively between countries. This was clearly observed in the systematic review that led this study. Moreover, since IPV is a highly multifaceted, gender-based phenomenon, literature is still inconsistent with regards to the variables that promote or hinder abuse during pregnancy. Hence, this study aimed to explore women's health and assess the frequency of IPV during pregnancy. In order to achieve this aim, the researcher investigated the socio-demographic variables associated with IPV during pregnancy and analysed whether IPV during the gestation period influenced pregnancy outcomes.

This study implemented a survey research design. The sample comprised of 300 Maltese postnatal women, recruited by convenience, non-proportional quota sampling technique, yielding a response rate of 78.9%. Data was collected by the Charge Midwives of the wards or their representatives; potential participants who met the inclusion and exclusion criteria and accepted to participate in the study were given a modified version of the WHO violence against women structured interview. The tool was previously validated in several countries worldwide and tested locally using test-retest reliability. This research strictly adhered to the WHO ethical considerations. The researcher also obtained ethical approval from the respective local authorities. Frequencies and cross-tabulations were used to analyse the data.

Findings show that 22.3% (n = 66) of all participants were exposed to one or more acts of psychological, verbal, physical or sexual abuse by their intimate partner during their pregnancy, implying that the ratio of IPV during pregnancy in Malta is 1-2 in every 5 women. Psychological and verbal IPV were the most common forms of violence experienced by women, followed by physical and sexual abuse. Results indicated that pregnancy was neither found to protect women nor increase their chances of experiencing physical acts of IPV. Several socio-demographic and pregnancy-related variables were found to significantly increase women's risk of experiencing IPV during pregnancy; including amongst others: young age or being older than 35 years, low education, working as a housewife, having a marital status of single or living with the partner out of wedlock, having a history of or occasional use of illicit drugs, having an unplanned pregnancy, requiring hospital admissions or experiencing physical injuries during pregnancy and having an infant weighing less than 1kg at birth.

By using Bronfenbrenner's (1979) ecological model and the gender theory (Hess & Ferree, 1987) as a guide, this study discussed how IPV during pregnancy cannot be fully comprehended unless cultural, religious and societal factors are taken into account. This study concludes by providing a number of recommendations for the clinical practice, education and research, based on the findings obtained; including amongst others, the introduction of routine screening for IPV during pregnancy and the need to offer health professionals continuous professional development courses, seminars and conferences on identification and management of abuse during pregnancy. Moreover, suggestions for awareness campaigns are also drawn up.

Keywords:

Women's health, pregnancy, intimate partner violence, survey, pregnancy outcomes, socio-demographic variables

Christie Debono
Master of Science (Midwifery)
University of Malta 2015

Somali Immigrant Women's Lived Experience of Pregnancy and Childbirth in Malta

This study aimed to understand the lived experiences of Somali immigrant women during pregnancy and childbirth in the Maltese context. The objectives of the study were to explore Somali women's experience of their pregnancy and childbirth in Malta, the needs of these women during pregnancy and childbirth and possible cultural barriers that Somali women faced during pregnancy and childbirth.

The qualitative paradigm was used to conduct the study by using a semi-structured interview. The interview guide was specifically designed for the purpose of this research. Eight women were chosen to participate in this study by purposive sampling. All participants took part in two interviews. The first interview, which was audio recorded, was conducted within 3 months following childbirth. The second interview focused on the verification of data and the interpretation derived from their first interview.

The focus of interpretative hermeneutic phenomenology, as described by vanManen (1990) was adapted to interpret the data. The resulting 6 major themes were 'struggling to adapt', 'a sense of security', 'healthcare challenges' 'faith and tradition' 'changes and beliefs' and 'shifting identities'.

The findings demonstrated that these women's lived experiences ranged as a continuum between two extremes, namely from a sense of trust to struggling to adapt to this new phenomenon. Findings also show that while Somali women try to adapt and trust the healthcare system, few attempts have been actually made, by the healthcare system to support them. This research recognises the dire need to research this phenomenon as it is of crucial importance in our society due to the continuous influx of immigrants. It highlights the need for healthcare professionals to have the capacity to work in a cross cultural environment by introducing a good interpreting system to overcome language barriers. Healthcare professionals, especially midwives, are identified as important figures that need to recognise women as individuals with particular stories and backgrounds in order to provide a safe and non-stereotyped maternity care. Hence, this study recommends that clinicians need to overcome both cultural and language barriers in order to provide optimum care.

Keywords: migrant women, Somali women/female, ethnic minority population, refugees, asylum seekers, maternity care, childbirth, cultural diversity population.

Stephania Vella Rapa
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Doctoral Research

The Design and Validation of a Framework of Competencies in Spiritual Care for Nurses and Midwives: A Modified Delphi Study

Instigated by an effort to counteract incidences of dissatisfaction in the provision of nursing/midwifery care reported in stories of undignified care, clients' suffering and the demands of clients requesting a more personalised, sensitive and compassionate care and greater client choice, were the roots of my investigation. On examination, the roots of dissatisfaction with care can be traced to the neglect of the spiritual dimension in care such as shown by nurses'/midwives' lack of caring attitudes and values and lack of compassion in practice (Francis, 2013). These reinforce the importance of nurses/midwives adopting a holistic client-centred care through competencies that define the expectations for performance and scope of nursing/midwifery practice.

The study adopted a mixed methods approach, using an eclectic framework through three main phases. In **Phase 1**, spiritual care competencies were categorised under seven domains which were developed from an in-depth literature review and five focus groups with stakeholders.

In **Phase 2,** the competency framework underwent two rounds of consensus by experts using a modified Delphi method with high response rates (R1: 75.78%; n=241; R2: 85.06%; n=205). No significant differences were identified between the characteristics of Round 2 respondents and non-respondents which enhanced the reliability of the consensus reached on 54 competency items arranged in seven domains. Consensus was assumed if experts rated items within the highest region on a 7-point Likert form scale (5, 6, or 7) and a predetermined cut-off point of 75% threshold or greater. A six factor model was identified through the exploratory factor analysis which paralleled five of the original domains.

During consultation with international researchers in the field and modified Delphi educators (n=107) (**Phase 3**), 38 competency items were categorised as achievable at pre-registration level, the majority of which are consistent with existing pre-registration regulatory education requirements. Fifteen items were categorised as being achievable at post-registration level and one item was common at both levels. Thus, two competency frameworks were produced namely, a 39 item pre-registration framework and a 16 item post-registration framework. Thematic analysis identified enhancers/inhibitors to the implementation of the framework in education, research and/or clinical practice.

The key outputs of the research include:

The identification of a reliable, valid and psychometrically rigorous generic framework of competencies for spiritual care from an extensive literature review as well as focus groups with stakeholders, service-users and service providers.

The development of a conceptual framework for spiritual care based on the 'Theory of skill acquisition: Novice to expert' (Benner, 1984) and 'Taxonomy of educational objectives: Cognitive and affective domains' (Bloom, 1956).

The formulation of a **seven domain spiritual care competency framework for pre-registration level** and a **four domain competency framework at post-registration level in nursing/midwifery.** These competencies were cross-referenced with the regulatory bodies requirements (NMC 2009; 2010) and were endorsed by the local experts and international researchers who were involved in the study.

The identification of factors which may enhance and/or hinder the implementation of the framework in education, clinical practice and healthcare policy by consultation with international researchers and local modified Delphi educators.

The development of a generic framework of competencies in spiritual care provides new knowledge on the delivery of spiritual care by nurses/midwives to guide education and clinical practice. Recommendations are given for education, clinical practice and policy. Further research is needed to test both the pre- and post-registration frameworks of competencies which emerged from the consultation phase of the study.

Dr. Josephine Attard PhD
University of South Wales

Lived Realities of Nicu-To-Home Transition in Malta: The Experiences of Parents of Preterm Infants, and of Neonatal Staff

Preterm birth and the premature infant have been predominately studied from clinical perspectives. The experiences of parenting a preterm child and the experiences of staff directly involved in the care of preterm infants have been studied much less. Additionally, less is known about the meaning of experiences around the preterm infant's discharge from the neonatal unit and life at home thereafter. This study addresses these gaps identified in research and aims to generate a deeper understanding of the meanings, and lived experiences of NICU-to-home transition from multiple perspectives: mothers and fathers, and neonatal staff.

This is a Heideggerian hermeneutic phenomenological study of the experiences of Maltese parents of preterm infants and, of neonatal staff of NICU-to-home transition. Using purposive sampling, open interviews were conducted with 9 mother-father dyads of preterm infants and 12 neonatal staff that included midwives, nurses and doctors working on the only neonatal unit in Malta. A modified vignette technique based on the parents' interviews was used to stimulate reflective talk with the staff. A longitudinal design was adopted for data collection from the parents: at 1 month, 3 months and 6 months after discharge of their baby from the unit. The research process including analysis of the data was guided by van Manen (1990).

The parents' experiences of NICU-to-home transition are represented through four main themes: 'Shadowed by fading clouds of uncertainty', 'Reaching out', 'Watching vigilantly' and 'Living the new family'. In addition, three main themes emerged from the staff data: 'Acknowledging good practice', 'Realising limits' and 'Awakening to needed improvements in care'. Findings indicate that, in the longer term in the home setting, parents translated their parenting approaches through the norms of neonatal unit routines and practices. Staff findings revealed that care focuses primarily on producing technically prepared parents in infant care which arises out of their sense of responsibility towards the babies' wellbeing that extends to after being discharged from the neonatal unit.

A further in-depth interpretation and synthesis of the findings was undertaken drawing on the philosophy of Heidegger (1962). This revealed 'oscillating realities' between parents' and staff experiences, particularly in the degree to which they endeavoured to solicitude which 'leaped in' or 'leaped ahead', and the extent to which technocratic ways of Being permeated their relationships to each other and to the babies. Implications of the findings and suggestions for further research emerged from this study.

Dr Rita Pace Parascandalo PhD
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